# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| **Type of Requestor:** (x) HCP ( ) IE ( ) IC | **Response Timely Filed?** () Yes (x) No |
|---|---|
| Requestor's Name and Address<br>Wol-Med Clinics<br>2436 I-35 East South, Suite 336<br>Denton, Texas 76205 | MDR Tracking No.: M4-04-2101-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>Transportation Insurance Company<br>C/O Burns, Anderson, Jury & Brenner<br>P O Box 26300<br>Austin, Texas 78755-0300<br>Box 47 | Date of Injury:<br>Employer's Name: StaffAmerica, Inc.<br>Insurance Carrier's No.: 2E806356 |

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 11/20/02 | 11/20/02 | 99213 | $9.60 | $9.60 |
| 11/21/02 | 11/21/02 | 99213 | $9.60 | $9.60 |
| | | | | |
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## PART III: REQUESTOR'S POSITION SUMMARY

"This clinic does not participate in any Worker's Compensation PPOs or HMOs. We have attached documentation to support this."

## PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely. Denials listed on the EOBs state, "C-Negotiated Contract."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The requestor submitted information indicating that the Chronic Pain Program for the dates of service 02/21/03 through 03/07/03 have been paid and are no longer in dispute except the office visits listed above.

The carrier did not refute the provider's position that a contract does not exist between both parties. Therefore, the charges will be reviewed per the MFG.

The provider submitted documentation that supports the requirements of services billed per MFG E/M (IV).

Therefore, based on this information additional reimbursement is recommended.

**PART VI: DETAIL FINDINGS (If needed)**

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| | | | | **Total Left Column:** | | | $0.00 |
| | | | | **Total Amount Due:** | | | $19.20 |

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$19.20**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

**Ordered by:**

| | Michael Bucklin | 02/16/05 |
|---|---|---|
| Authorized Signature | Typed Name | Date of Order |

**PART VIII: YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____